DEPARTM	MENT OF HEALTH	AND HUMAN SERVICES			FORM AT	PPROVED 938-0391
CENTERS	S FOR MEDICARE OF DEFICIENCIES CORRECTION	& MEDIC. SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SUR COMPLETE	VEY
		445167	B. WING		06/27/	2011
	YEARD DESIGIENCY	SSVILLE ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	80 JI	T ADDRESS, CITY, STATE, ZIP CODUSTICE ST DSSVILLE, TN 38555 PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION SHOULD BE	(X5) COMPLETION DATE
SS=F	Doors protecting of required enclosure hazardous areas at those constructed wood, or capable of minutes. Doors in required to resist to impediment to are provided with a the door closed. If are permitted.	orridor openings in other than as of vertical openings, exits, or are substantial doors, such as of 1% inch solid-bonded core of resisting fire for at least 20 sprinklered buildings are only the passage of smoke. There is the closing of the doors. Doors a means suitable for keeping outch doors meeting 19.3.6.3.6 9.3.6.3 prohibited by CMS regulations acilities.	5	A. What corrective action(s) will for those residents found to have 1), 2) Between 6/27/11 and 8/3/Environmental Services and Matassistant will adjust interior doo latching and ensure doors are inframe. By 8/3/11 Director of Environmental Services and Maintenance Assistant moved beds in room prevent door closure obstruction 6/29/11 and 8/3/11, the Director Services and Maintenance Assistant moved beds in room prevent door closure obstruction 6/29/11 and 8/3/11, the Director Services and Maintenance Assisten Industrial Services and Maintenance Assistence Industrial Services Industrial	the Director of Internance of	8/3/2011
	Based on observe facility failed to more corridor openings. The findings included the following frames: a. Resident room by Corridor's fire.	g		having the potential to be affect the same deficient practice and action will be taken? 1), 2) By 7/21/11 the Executive complete education with associate that they turn in work orders to any doors that do not latch in fin frame. 3) By 7/21/11 the Direction mental Services and Direction with he nursing associates requesting and move beds if obstructing of 7/12/11 the Executive Director education with Maintenance A Environmental Service Director fire/smoke doors close complete drills.	Director will character of Maintenance for rame or that stick ector of Nursing busekeeping and that they observe door closure. 4) By will complete ssistant and or to ensure that	8/3/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Executive Director

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the above findings and plans of correction are disclosable 14 following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 following the date of the following the date days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUN'N SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDIC. SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: 01 - MAIN BUILDING 01 AND PLAN OF CORRECTION A. BUILDING B. WING _ 06/27/2011 445167 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 80 JUSTICE ST LIFE CARE CENTER OF CROSSVILLE CROSSVILLE, TN 38555 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES 1D (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG K 018 Continued K 018 K 018 Continued From page 1 C. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice will 2. Observations on 6/27/11 at 10:30 AM, revealed not recur? the following doors were sticking to the door 1), 2) Maintenance Director/Maintenance Assistant/Director of Environmental Service will complete a weekly room-to-room audit for three a. Resident rooms 100, 102, 104, 115, 124, 127, months of doors in facility to ensure proper latching and absence of sticking. Corrections will 136, 149, 152 b. Exit doors located next to rooms 114 and 152 be made as needed. 3) Maintenance Director/Maintenance Assistant/Director of c. Employee's break room Environmental Service will complete a weekly d. Fire door located in the D corridor next to room-to-room audit of beds in facility to ensure employee's break room. they are not obstructing door closure. Corrections e. Conference room will be made as needed. 4) Maintenance Director/Maintenance Assistant/Director of 3. Observation of resident rooms 96 and 136 on Environmental Service will complete a weekly 6/27/11 at 11:08 AM, revealed the resident beds door-to-door audit for three months of fire/smoke doors in facility to ensure proper closure. were obstructing the closing of the doors. 8/3/2011 Corrections will be made to doors as needed. Observation on 6/27/11 at 12:15 PM, revealed the lobby's fire door located next to the bathroom D. How will the corrective action(s) be monitored to ensure the deficient did not close within the door frame. practice will not recur; i.e., what quality assurance program will be put into place. These findings were verified by the maintenance supervisor and acknowledged by the Results of weekly door latching, sticking, bed administrator during the exit conference on obstruction, and fire door closure audits will be 6/27/11. reported and reviewed by Executive Director, K 025 K 025 : NFPA 101 LIFE SAFETY CODE STANDARD Medical Director, Director of Nursing, Director of Marketing, Pharmacist, Director of Admissions, SS=F Smoke barriers are constructed to provide at Director of Social Service, Rehab Services Manager, Director of Activities, Director of least a one half hour fire resistance rating in Environmental Services, Dietary Manager, accordance with 8.3. Smoke barriers may Director Maintenance, Business Office Manager, terminate at an atrium wall. Windows are Health Information Manager, and Staff protected by fire-rated glazing or by wired glass Development Coordinator in Monthly QA meeting panels and steel frames. A minimum of two 8/3/2011 and corrections made as needed. separate compartments are provided on each K 025 floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted A. What corrective action(s) will be accomplished heating, ventilating, and air conditioning systems. for those residents found to have been affected; 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4

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DEPARTMENT OF HEALTH AND HUN TO SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAL SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: 01 - MAIN BUILDING 01 A. BUILDING AND PLAN OF CORRECTION 06/27/2011 B. WING _ 445167 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 80 JUSTICE ST LIFE CARE CENTER OF CROSSVILLE CROSSVILLE, TN 38555 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) TAG K 025 Continued K 025 On 6/29/11 Director of Environmental Service and K 025 Continued From page 2 Maintenance Assistant sealed penetrations in smoke barrier in attic above room 117; sealed smoke barrier to roof deck in attic above room 117; and sealed penetrations in draft wall in attic above D-Hall nurses station and installed door in This STANDARD is not met as evidenced by: 8/3/2011 6'X4' opening. Based on observations, it was determined the B. How will you identify other residents facility failed to maintain the smoke barriers having the potential to be affected by located in the attic. the same deficient practice and what corrective action will be taken? The findings include: By 8/3/11 the Executive Director will have Preventative Maintenance plan for frequent attlc 1. Observation on 6/27/11 at 9:45 AM, revealed penetration checks added to facility's online penetrations in the smoke barrier located in the 8/3/2011 prompting system. attic above room 117. C. What measures will be put into place or what systematic changes will you make 2. Observation on 6/27/11 at 9:47 AM, revealed to ensure that the deficient practice will the top of the smoke barrier located in the attic not recur? above room 117 was not sealed at the roof deck. Maintenance Director/Maintenance 3. Observation on 6/27/11 at 10:07 AM, revealed Assistant/Director of Environmental Service will the draft wall located in the attic above the D complete a weekly observation audit of attic for nurses' station had penetrations and a 6' x 4' three months to ensure penetrations are sealed. portion of the was removed. Corrections will be made to doors as needed. 8/3/2011 These findings were verified by the maintenance D. How will the corrective action(s) be monitored to ensure the deficient supervisor and acknowledged by the practice will not recur; i.e., what quality administrator during the exit conference on assurance program will be put into place. 6/27/11. K 039 NFPA 101 LIFE SAFETY CODE STANDARD K 039 Results of weekly attic penetration audit will be reported and reviewed by Executive Director, SS=E Medical Director, Director of Nursing, Director of Width of aisles or corridors (clear and Marketing, Pharmacist, Director of Admissions, unobstructed) serving as exit access is at least 4 Director of Social Service, Rehab Services 19.2.3.3 feet. Manager, Director of Activities, Director of Environmental Services, Dietary Manager, Director Maintenance, Business Office Manager, Health Information Manager, and Staff ! This STANDARD is not met as evidenced by: Development Coordinator in Monthly QA meeting Based on observations, it was determined the 8/3/2011 and corrections made as needed.

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DEPARTMENT OF HEALTH AND HUN TI SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICA. SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: 01 - MAIN BUILDING 01 A. BUILDING AND PLAN OF CORRECTION B. WING_ 06/27/2011 445167 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 80 JUSTICE ST LIFE CARE CENTER OF CROSSVILLE CROSSVILLE, TN 38555 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG DEFICIENCY) TAG K 039 K 039 K 039 Continued From page 3 A. What corrective action(s) will be accomplished facility failed to maintain the corridors clear of for those residents found to have been affected: equipment. On 6/27/11 lift was moved from hallway by CNA. 8/3/2011 The findings include: B. How will you identify other residents Observation 6/27/11 at 9:44 AM, revealed a lift having the potential to be affected by the same deficient practice and what corrective was stored in the corridor next to room 163. Further observation at 10:18 AM, revealed the lift action will be taken? By 7/21/11 the Executive Director/Director of remained in the corridor for more then 30 Nursing will complete education with minutes. RNs/LPNs/CNAs to store lifts off hallway when 8/3/2011 not in use. This finding was verified by the maintenance supervisor and acknowledged by the C. What measures will be put into place or administrator during the exit conference on what systematic changes will you make to ensure that the deficient practice will 6/27/11. K 050 NFPA 101 LIFE SAFETY CODE STANDARD K 050 not recur? SS=F Fire drills are held at unexpected times under Maintenance Director/Maintenance Assistant/Director of Environmental Service will varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware complete a weekly observation audit of comidors for three months to ensure lifts are properly that drills are part of established routine. stored. Corrections will be made as needed. 8/3/2011 Responsibility for planning and conducting drills is assigned only to competent persons who are D. How will the corrective action(s) be qualified to exercise leadership. Where drills are monitored to ensure the deficient conducted between 9 PM and 6 AM a coded practice will not recur; i.e., what quality announcement may be used instead of audible assurance program will be put into place. 19.7.1.2 Results of weekly lift storage audit will be alarms. reported and reviewed by Executive Director, Medical Director, Director of Nursing, Director of Marketing, Pharmacist, Director of Admissions, Director of Social Service, Rehab Services This STANDARD is not met as evidenced by: Based on observations, it was determined the Manager, Director of Activities, Director of Environmental Services, Dietary Manager, facility failed the fire drill. Director Maintenance, Business Office Manager, Health Information Manager, and Staff The findings include: Development Coordinator in Monthly QA meeting 8/3/2011 and corrections made as needed. Observation during the fire drill on 6/27/11 at

12:54 PM, revealed staff member #1 failed to

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PRINTED: UQ/3U/ZUTT FORM APPROVED DEPARTMENT OF HEALTH AND HUN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAL SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: 01 - MAIN BUILDING 01 AND PLAN OF CORRECTION A. BUILDING B. WING 06/27/2011 445167 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 80 JUSTICE ST LIFE CARE CENTER OF CROSSVILLE CROSSVILLE, TN 38555 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES COMPLETION ID (EACH CORRECTIVE ACTION SHOULD BE (X4) 1D PREFIX DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) TAG K 050 A, What corrective action(s) will be accomplished K 050 for those residents found to have been affected: K 050 : Continued From page 4 clear and removal the residents from the room On 7/12/11, the Executive Director completed inservice with staff member #1 on proper room where the fire drill was occuring. 8/3/2011 evacuation procedures in case of fire. This finding was verified by the maintenance B, How will you identify other residents supervisor and acknowledged by the having the potential to be affected by administrator during the exit conference on the same deficient practice and what corrective action will be taken? 6/27/11.

K 062

SS=E

K 062 NFPA 101 LIFE SAFETY CODE STANDARD

Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested 19.7.6, 4.6.12, NFPA 13, NFPA periodically. 25, 9.7.5

This STANDARD is not met as evidenced by: Based on observations and records review, it was determined the facility failed to maintain the sprinkler system

The findings include:

Records review on 6/27/11 at 1:18 PM, revealed the facility to conduct the required quarterly sprinkler inspections during the 1st quarters of 2010 and 2011.

This finding was verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on 6/27/11.

\$\$=F

K 069 NFPA 101 LIFE SAFETY CODE STANDARD

Cooking facilities are protected in accordance 19.3.2.6, NFPA 96 with 9.2.3.

By 7/21/11, the Executive Director/Director of Environmental Services/Maintenance Assistant will complete education of Dietary, Housekeeping, Laundry, Rehab, Nursing, Business Office, and Maintenance associates on proper procedures for 8/3/2011 evacuating patient room in case of fire.

C. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice will not recur?

Maintenance Director/Maintenance Assistant/Director of Environmental Service will complete a monthly observation audit for three months during monthly fire drills to ensure that rooms are properly evacuated. Education will be completed as needed.

D. How will the corrective action(s) be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.

Results of monthly room evacuation audits will be reported and reviewed by Executive Director, Medical Director, Director of Nursing, Director of Marketing, Pharmacist, Director of Admissions, Director of Social Service, Rehab Services Manager, Director of Activities, Director of Environmental Services, Dietary Manager, Director Maintenance, Business Office Manager, Health Information Manager, and Staff Development Coordinator in Monthly QA meeting and corrections made as needed.

K 069 ·

Facility ID: TN1801

If continuation sheet Page 5 of 10

8/3/2011

8/3/2011

PRINTED: 06/30/2011 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: 01 - MAIN BUILDING 01 AND PLAN OF CORRECTION A. BUILDING B. WING 06/27/2011 445167 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 80 JUSTICE ST LIFE CARE CENTER OF CROSSVILLE CROSSVILLE, TN 38555 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES 1D (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG K 062 A. What corrective action(s) will be accomplished K 050 for those residents found to have been affected: K 050 | Continued From page 4 On 6/27/11, a sprinkler inspection was scheduled clear and removal the residents from the room by the Executive Director. The sprinkler where the fire drill was occuring. inspection was completed 7/1/11 by a sprinkler 8/3/2011 inspection company. This finding was verified by the maintenance B. How will you identify other residents supervisor and acknowledged by the having the potential to be affected by administrator during the exit conference on the same deficient practice and what corrective 6/27/11. action will be taken? K 062 NFPA 101 LIFE SAFETY CODE STANDARD K 062 By 7/21/11 the Executive Director will complete SS=E Required automatic sprinkler systems are education with Maintenance Assistant and continuously maintained in reliable operating Director of Environmental Services on timely, 8/3/2011 condition and are inspected and tested quarterly completion of sprinkler inspection. 19.7.6, 4.6.12, NFPA 13, NFPA periodically. C. What measures will be put into place or 25, 9.7.5 what systematic changes will you make to ensure that the deficient practice will not recur? This STANDARD is not met as evidenced by: The Executive Director will complete audit of Based on observations and records review, it facility's online preventative maintenance was determined the facility failed to maintain the prompting and tracking system to ensure quarterly timely completion of sprinkler sprinkler system Inspection. Corrections will be made if needed. 8/3/2011 The findings include: D. How will the corrective action(s) be monitored to ensure the deficient Records review on 6/27/11 at 1:18 PM, revealed practice will not recur; i.e., what quality the facility to conduct the required quarterly assurance program will be put into place. sprinkler inspections during the 1st quarters of Results of quarterly sprinkler Inspection audit will 2010 and 2011. be reported and reviewed by Executive Director, Medical Director, Director of Nursing, Director of This finding was verified by the maintenance Marketing, Pharmacist, Director of Admissions, Director of Social Service, Rehab Services supervisor and acknowledged by the administrator during the exit conference on Manager, Director of Activities, Director of Environmental Services, Dietary Manager, 6/27/11. Director Maintenance, Business Office Manager, K 069 K 069 NFPA 101 LIFE SAFETY CODE STANDARD Health Information Manager, and Staff Development Coordinator in Monthly QA meeting SS=F Cooking facilities are protected in accordance and corrections made as needed. 8/3/2011 19.3.2.6, NFPA 96 with 9.2.3.

PRINTED: 06/30/2011 FORM APPROVED OMB-NO: 0938-0391

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION 01 - MAIN BUILDING 01 A. BUILDING B. WING 06/27/2011 445167 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 80 JUSTICE ST LIFE CARE CENTER OF CROSSVILLE CROSSVILLE, TN 38555 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG K 069 A. What corrective action(s) will be accomplished K 069 K 069 Continued From page 5 for those residents found to have been affected: 1) On 6/29/11 kitchen's tilt skillet was centered This STANDARD is not met as evidenced by: between rails over fire extinguishing nozzles by Based on observations and interviews, it was Maintenance Assistant and Director of Environmental Services, 2) Replacement filter for determined the facility failed to maintain and kitchen hood system was ordered 7/11/11 by protect the cooking facilities. Director of Environmental Services, 3) Instructions for manually operating the kitchen's The findings include: hood fire-extinguishing system were posted by Dietary Service Manager on 7/14/11. Inservice for 1. Observation of the kitchen's hood system on Dietary associates was given by Certified Dietary 12:20 PM, revealed the tilt skillet was not center Manager on 7/14/11 regarding manually operating kltchen's hood fire-extinguishing system 4) On over the fire extinguishing nozzles. 7/14/11 staff member #1 was in-serviced by Dietary Service Manager on manual operation of 2. Observation of the kitchen's hood system on kitchen's hood fire-extinguishing system and 6/27/11 at 12;21 PM, revealed a damaged filter. proper protocol for extinguishing electrical or grease fires. 5) Director of Environmental 3. Observation of the kitchen on 6/27/11 at 12:40 Services scheduled kitchen's hood cleaning for PM, revealed there were no instructions for 7/19/11, 6) On 7/6/11 the Director of manually operating the kitchen's hood Environmental Services scheduled securement of exhaust fan to exhaust duct assembly on roof to fire-extinguishing system posted conspicuously in 8/3/2011 the kitchen. The instructions shall be reviewed be completed by 8/3/11. periodically by the employees. B. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective 4. Interview with kitchen staff member #1 on 6/27/11 at 12:41 PM, revealed that staff member action will be taken? By 7/21/11 the Executive Director/Dietary Service #1 did not know how to manually operate the kitchen's hood fire extinguishing system. Staff Manager/Director of Environmental Services/Fixed Suppression System company will member #1 was not properly trained in how to complete education with Dietary associates on extinguish an electrical or grease fire. correct placement of 1) tilt skillet, 2) proper reporting to supervisor of damaged equipment in 5. Record review on 6/27/11 at 1:20 PM, revealed kitchen, 3) placement of intrusions for manual the kitchen's 6 month hood cleaning was overdue operation of kitchen's hood fire-extinguisher system, 4) directions for manually operating (May 11). kitchen's hood fire-extingulsher system and extinguishing process for electrical and grease 6. Observation of the kitchen's hood exhaust fan fires. 5), 6) By 7/21/11, the Executive Director will on 6/27/11 at 1:25 PM, revealed the roof mounted educate Maintenance Assistant and Director of exhaust fan was not secured to the exhaust duct Environmental Services on hood cleaning schedule requirements and proper securement of assembly... 8/3/2011 exhaust fans for exhaust duct assembly.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SU AND PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE SUF COMPLET	
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	OVIDER OR SUPPLIER	SSVILLE		REET ADDRESS, CITY, STATE, ZIP CODE 80 JUSTICE ST CROSSVILLE, TN 38555		
(X4) ID PRÉFIX TAG	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IQULD BE	(X5) COMPLETION DATE
DEDUCATORY OF LCC IDENTIFYING INFORMATION		K 06	C. What measures will be put into what systematic changes will you to ensure that the deficient practic not recur? The Director of Maintenance/Mainte	put into place or will you make t practice will ce/Maintenance onmental Services will atton audit for three ct tilt skillet placement aintenance 3) correct for manual operation of sishing system 6) ament to exhaust duct ector of a Assistant/Director of certified Dietary Manager service with Dietary and understanding of 4) differ-extinguishing ructions, and procedure I or grease fires. 5) induct an observation eventative maintenance yetem to ensure hood ely. Corrections will be 8/3/2011		
	6/27/11 at 12:41 F #1 did not know hi kitchen's hood fire member #1 was n extinguish an elect 5. Record review the kitchen's 6 mo (May 11). 6. Observation of on 6/27/11 at 1:25	itchen staff member #1 on PM, revealed that staff member ow to manually operate the extinguishing system. Staff not properly trained in how to strical or grease fire. on 6/27/11 at 1:20 PM, revealed on the kitchen's hood exhaust fan 5 PM, revealed the roof mounted not secured to the exhaust duct		practice will not recur; i.e., what of assurance program will be put into Results of audits for 1) tilt skillet, maintenance, 3) instruction place kitchen's hood fire-extinguisher at for electrical and grease fire, and cleaning and 6) exhaust fan securevlewed by Executive Director, in Director of Nursing, Director of Meharmacist, Director of Admission Social Service, Rehab Services in Director of Activities, Director of Services, Dietary Manager, Director of Business Office Manager, Health Manager, and Staff Development Monthly QA meeting and correct needed.	o place. 2) hood filter ment 4) udit, procedure 5) hood rement will be Medical Director, arketing, ns, Director of Manager, Environmental tor Maintenance. Information	8/3/2011

DEPARTMENT OF HEALTH AND HUM IN SERVICES CENTERS FOR MEDICARE & MEDIC. SERVICES

NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF CROSSVILLE SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCY REGOVER PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCY SUMMARY STATEMENT OF DEFICIENCY ROOSVILLE, TN 38555 ROOSVILLE, TN 38555 ROOSVILLE, TN 38555 ROOSVILLE, TN 38555 ROOVER TO SHAPP OF DEFICIENCY ROOS STATEMENT OF DEFICIENCY ROOS STATEMENT OF DEFICIENCY ROOS STATEMENT OF CONSTRUCT ROOS STATEMENT OF DEFICIENCY ROOT OF	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	01 - MAIN BUILDING 01	COMPLETED
LIFE CARE CENTER OF CROSSVILLE INCLIDED SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAB SECTION SHOULD BE CHOSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 069 Continued From page 6 These findings were verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on 6/27/11. K 076 NFPA 101 LIFE SAFETY CODE STANDARD SS=F Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to protect the oxygen storage room. The findings include: 1. Observation of the oxygen storage room on 6/27/11 at 10.55 AM, revealed 2 unsecured oxygen cylinders. 2. Observations of the oxygen storage room on 6/27/11 at 10.55 AM, revealed the electrical outlets and flights on/off switch were not installed 5 feet above the floor.			445167			06/27/2011
ROBERT RECULATORY OR LSC IDENTIFYING INFORMATION) REGULATORY OR LSC IDENTIFYING INFORMATION REGULATORY OR LSC IDENTIFYING INFORMATION) REGULATORY OR LSC IDENTIFYING INFORMATION REGULATORY OR LSC IDENTIFYING I			SSVILLE	80 JC	JSTICE ST DSSVILLE, TN 38555	
These findings were verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on 6/27/11. K 076 NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99. Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to protect the oxygen storage room. The findings include: 1. Observation of the oxygen storage room on 6/27/11 at 10:55 AM, revealed 2 unsecured oxygen cylinders. 2. Observations of the oxygen storage room on 6/27/11 at 10:55 AM, revealed the electrical outlets and the lights on/off switch were not installed 5 feet above the floor.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(ÉACH CORRECTIVE ACTION SHO CROSS-RÉFÉRENCED TO THE APPI	OULD BE COMPLETION
3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to protect the oxygen storage room. The findings include: 1. Observation of the oxygen storage room on 6/27/11 at 10:55 AM, revealed 2 unsecured oxygen cylinders. 2. Observations of the oxygen storage room on 6/27/11 at 10:56 AM, revealed the electrical outlets and the lights on/off switch were not installed 5 feet above the floor.	K 076	These findings we supervisor and ac administrator durin 6/27/11. NFPA 101 LIFE S Medical gas storal protected in accordand for Health (a) Oxygen storag 3,000 cu.ft. are er	re verified by the maintenance knowledged by the ng the exit conference on AFETY CODE STANDARD ge and administration areas are dance with NFPA 99, alth Care Facilities.		A. What corrective action(s) will be for those residents found to have be On 6/27/11, unsecured oxygen cylin secured in cylynder crate by Directo Environmental Services, 2) On 6/29/outlets and light on/off switch were reinstalled by electrical company to	neen affected: Inders were or of 11, electrical moved and be five feet
This finding was verified by the maintenance		3,000 cu.ft. are ve 4.3.1.1.2, 19.3.2. This STANDARD Based on observation of facility failed to protect The findings inclusion. 1. Observation of 6/27/11 at 10:55 oxygen cylinders. 2. Observations 6/27/11 at 10:56 outlets and the light installed 5 feet all	is not met as evidenced by: ration, it was determined the rotect the oxygen storage room. Ide: If the oxygen storage room on AM, revealed 2 unsecured of the oxygen storage room on AM, revealed the electrical ghts on/off switch were not boove the floor.		having the potential to be affected to the same deficient practice and who action will be taken? 1) By 7/21/11, the Director of Nursi Services Manager will complete ed RN/LPN/CNA/Rehab associates or storage of oxygen cyclynders. By 7 Executiva Director will complete ed Director of Environmental Services a Maintenance Assistant on proper pelectrical outlets and switches in oxygen.	at corrective ng/Rehab ucation with n secure /21/11, the ucation with and lacement of kygen storage
		This finding was	verified by the maintenance			

DEPARTMENT OF HEALTH AND HU" N SERVICES CENTERS FOR MEDICARE & MEDIC. ... SERVICES

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MUL		ÇOI		E SURVEY PLETED	
		445167	B. WING			06/27	7/2011	
LIFE CAF	ROVIDER OR SUPPLIER	SSVILLE	ID.	80 JU	ADDRESS, CITY, STATE, ZIP CODE ISTICE ST SSVILLE, TN 38555 PROVIDER'S PLAN OF CORRECT	TION	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OLD BE	COMPLÉTION DATE	
K 076 SS=F	supervisor and ack administrator durin 6/27/11. NFPA 101 LIFE SA Medical gas storag protected in accord Standards for Heal (a) Oxygen storage 3,000 cu.ft. are end separation. (b) Locations for su	re verified by the maintenance inowledged by the g the exit conference on AFETY CODE STANDARD are and administration areas are dance with NFPA 99. Ith Care Facilities. It locations of greater than closed by a one-hour apply systems of greater than inted to the outside. NFPA 99	K 06		K 076 Continued C. What measures will be put into ply what systematic changes will you may to ensure that the deficient practice of not recur? The Director of Maintenance/Mainter Assistant/Director of Environmental Stronduct a weekly observation audit months of the oxygen storage room proper securement and safety of oxycylinders. Corrections will be made at D. How will the corrective action(s) is monitored to ensure the deficient practice will not recur: i.e., what qual assurance program will be put into proceed to the strong program will be put into proceed to the strong program will be put into proceed to the strong program will be put into proceed to the strong program will be put into proceed to the strong program will be put into proceed to the strong program will be put into proceed to the strong program will be put into proceed to the strong program will be put into proceed to the strong program will be put into proceed to the strong program will be put into proceed to the strong program will be put into proceed to the strong program will be put into proceed to the strong program will be put into proceed to the strong	nance fervices will for three to ensure gen as needed.	\$/3/2011	
	Based on observational facility failed to promote the findings included the findings in the figure of the first and the figure installed 5 feet above.	the oxygen storage room on M, revealed 2 unsecured fithe oxygen storage room on M, revealed the electrical onto on/off switch were not			Results of oxygen safety storage au reviewed by Executive Director, Med Director of Nursing, Director of Mark Pharmacist, Director of Admissions, Social Service, Rehab Services Mar Director of Activities, Director of Env Services, Dietary Manager, Director Business Office Manager, Health Int Manager, and Staff Development Co Monthly QA meeting and corrections needed.	dical Director, leting, Director of leager, lironmental Maintenance, formation cordinator in	8/3/2011	

DEPARTMENT OF HEALTH AND HUN SERVICES
CENTERS FOR MEDICARE & MEDICAL SERVICES

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	WALLEL TIDLE	CONSTRUCTION	(X3) DATE SURV	/EY
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		COMPLETED	
		445167	B. WING		06/27/	2011
	ROVIDER OR SUPPLIER		80 JI	T ADDRESS, CITY, STATE, ZIP CODI USTICE ST DSSVILLE, TN 38555	Ē	
(X4) 1D PREFIX TAG	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	יייייייייייייייייייייייייייייייייייייי	(X5) COMPLETION DATE
	Continued From pa	age 7	K 076	K 130 A. What corrective action(s) will for those residents found to have	be accomplished been affected:	
	supervisor and act administrator durin 6/27/11 NFPA 101 MISCE	knowledged by the ng the exit conference on	K 130	 Director of Environmental Ser Maintenance Assistant sealed potential located in the attic above 7/8/11. 2) Director of Maintenant Environmental Services/Mainter will conduct a Health Care Emer 8/3/11. 	room 146 by ce/Director of lance Assistant	8/3/11\
	This STANDARD Penetrations and barriers such as p cables, wires, air ducts, and similar pass through fire material that is ca resistance of the Health Care Eme Each organization more specific res preparedness pla least one semi-air casualty respons emergency service or both.	is not met as evidenced by: miscellaneous openings in fire sipes, conduits, bus ducts, ducts, pneumatic tubes and building service equipment that barriers shall be filled with a spable of maintaining the fire fire barrier. rgency Preparedness Drills: nal entity shall implement one or ponses of the emergency in at least semi-annually. At nnual drill shall rehearse mass e for health care facilities with ces, disaster receiving stations,		B. How will you identify other reshaving the potential to be affacts the same deficient practice and action will be taken? By 7/21/11, the Executive Direct education with Director of Environt and Maintenance Assistant on annual Emergency Preparedne C. What measures will be put in what systematic changes will you to ensure that the deficient practice of the executive Director will and preventative maintenance onling prompting system for timely (secompletion of Emergency Prepared to ensure the deficient practice will the corrective action monitored to ensure the deficient practice will not recur; i.e., who assurance program will be put	tor will complete commental Services conducting semi-ss Drills. Into place or our make ctice will it facility's ne tracking and emi-annual) paredness Drills. Into place or our make ctice will it facility's ne tracking and emi-annual) paredness Drills. Into place.	8/3/2011 8/3/2011
	determined the factoriers and faile Care Emergency The findings incl	on 6/27/11 at 9:48 AM, revealed he fire barrier located in the attic		Results of Emergency Prepare reviewed by Executive Director of Pharmacist, Director of Pharmacist, Director of Admis Social Service, Rehab Service Director of Activities, Director Services, Dietary Manager, D Business Office Manager, He Manager, and Staff Developm Monthly QA meeting and corneeded.	ir, Medical Director, f Marketing, isions, Director of es Manager, of Environmental frector Maintenance alth Information ment Coordinator in	

DEPARTMENT OF HEALTH AND HUN SERVICES
CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 06/30/2011 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER. Q1 - MAIN BUILDING 01 A. BUILDING AND PLAN OF CORRECTION B. WING 06/27/2011 445167 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 80 JUSTICE ST LIFE CARE CENTER OF CROSSVILLE CROSSVILLE, TN 38555 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG K 147 A. What corrective action(s) will be accomplished for those residents found to have been affected: K 130 K 130 Continued From page 8 1) Electrical company applied protective cover to Record review on 6/27/11 at 1:23 PM. electrical circuit breaker box in attic above D-Hall revealed the facility failed to conduct the required nurses station by 7/8/11. 2) Electrical company Health Care Emergency Preparedness Drills. applied protective cover to heating and cooling unit located in the attic above D-Hall nurses These findings were verified by the maintenance station by 7/8/11. 3) Maintenance Assistant removed extension chord in use in attic above Dsupervisor and acknowledged by the Hall nurses station by 6/29/11. 4) Director of administrator during the exit conference on Environmental Services and Maintenance 6/27/11. Assistant applied protective cover to back of dryer K 147 NFPA 101 LIFE SAFETY CODE STANDARD K 147 8/3/2011 SS=E Electrical wiring and equipment is in accordance B. How will you identify other residents with NFPA 70, National Electrical Code, 9.1.2 having the potential to be affected by the same deficient practice and what corrective action will be taken? This STANDARD is not met as evidenced by: By 7/21/11 the Executive Director will complete Based on observations, it was determined the education with Director of Environmental Services facility failed to maintain the electrical equipment and Maintenance Assistant on use of covers for 1) breaker boxes, 2), 4) electrical wiring, and located in the attic. 8/3/2011 3)proper use of extension chords. The findings include: C. What measures will be put into place or what systematic changes will you make 1. Observation on 6/27/11 at 10:07 AM, revealed to ensure that the deficient practice will the electrical circuit breaker box located in the not recur? attic above the D nurses' station was missing the The Director of Maintenance/Maintenance protected cover. Assistant/Director of Environmental Services will conduct a monthly observation audit for three 2. Observation on 6/27/11 at 10:08 AM, revealed months of attic breaker boxes, attic heating and the heating and cooling unit located in the attic cooling units and linen dryers to ensure proper above the D nurses' station had exposed protective covers are in place. The Director of Maintenance/Maintenance Assistant/Director of electricall wires with no protected cover. Environmental Services will conduct a weekly observation audit for three months of extension 3. Observation on 6/27/11 at 10:09 AM, revealed chords used in attic. Corrections will be made as an extension cord was being used in the attic 8/3/2011 needed. above the D nurses' station. Observation of the laundry room on 6/27/11 at

DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

CENTER	S FOR MEDICARE	& MEDICAL SERVICES			CONTRACTION	(X3) DATE SUF	RVEY
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IULTIPLE ILDING	CONSTRUCTION 01 - MAIN BUILDING 01	COMPLET	ED	
		445167	B. WI		NA.	06/27	/2011
NAME OF P	ROVIDER OR SUPPLIER	***			T ADDRESS, CITY, STATE, ZIP COD	Ē	
LIFE CAF	RE CENTER OF CRO	SSVILLE			USTICE ST DSSVILLE, TN 38555		
			tD.		PROVIDER'S PLAN OF CORE	RECTION	(X5) COMPLETION
(X4) 1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREF		(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	PPROPRIATE	DATE
K 147	Continued From pa	age 9	К	147	K 147 Continued	1	
K 147 Continued From page 9 12:27 PM, revealed the back of dryer #3 had exposed electrical wires with no protected cover. These findings were verified by the maintenance			D. How will the corrective action monitored to ensure the deficient practice will not recur; i.e., what assurance program will be put it		nt ; quality		
	supervisor and acl	knowledged by the ng the exit conference on	:	!	Results of oxygen storage audit		
	6/27/11.				by Executive Director, Medical I of Nursing, Director of Marketing Director of Marketing Director of Admissions, Director Rehab Services Manager, Director Manager, Director Maintenance Manager, Health Information Mi Development Coordinator in Mo and corrections made as neede	Director, Director g, Pharmacist, r of Social Service, stor of Activities, ces, Dietary r, Business Office anager, and Staff onthly QA meeting	8/3/2011
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